PPO NETWORKS AND PARTICIPATING PROVIDERS

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Life & Health Section
85 Seventh Place East, St. Paul, Minnesota 55101-2198

Definition of PPO Networks/ Participating Providers

- Networks of participating providers as designated by the insurer in accordance with Minn. Stat. §72A.20, Subd. 15, clause (4).

- Participating Provider also includes a provider who is party to a service agreement with a service plan corporation. (Minn. Stat. §62C.02)

A service plan corporation may act for, or as agent of, a provider and may contract with subscribers and others to render or provide health services for the benefit of subscribers. It may enter into service agreements. A subscriber contract may provide for payment to, or reimbursement of, a subscriber for expenses incurred for health services when rendered or furnished by non-participating providers. (Minn. Stat. §62C.13, Subd. 1)

62A.60 Retroactive Denial of Expenses

62J.71 Prohibited Provider Contracts

62J.72 Written Disclosure of Health Care Provider Information

62J.73 Prohibition on Exclusive Arrangements

62J.74 Enforcement

62M Utilization Review Organizations – Entire Chapter

62Q.01 Requirements for Health Plan Companies, Definitions

Subd 5. Managed Care Organization Defined

62Q.12 Denial of Access

62Q.23 General Services

This requirement clarifies the application of sections Minn. Stat. §62A.047, Minn. Stat. §62A.27, and any other coverage required under Chapter 62A of newborn infants, dependent children who do not reside with a covered person, disabled children and dependents, and adopted children. A health plan company providing dependent coverage shall comply with section Minn. Stat. §62A.302. Additionally, health plan companies shall comply with the equal access requirements of section Minn. Stat. §62A.15.

62Q.49 Enrollee Cost Sharing; Negotiated Provider Payments

62Q.78 Dental Benefit Plan Requirements

Subd. 3. Treatment Options.

No contractual provision between a dental organization and a dentist shall in any way prohibit or limit a dentist from discussing all clinical options for treatment with the patient.

72A.20 Regulation of Trade Practices

Subd. 15, Clause 4, Preferred Provider Compliance
In addition to the requirements of Minn. Stat. §72A.20, Subd. 15, Clause 4 the department expects disclosure and compliance with the following:

- The geographical area serviced by this provider network must be identified;
- The department does not consider a “closed panel” PPO to be in the public interest;
- The range of benefit differentials between preferred providers and non-network providers must be identified;
- The PPO must be clearly identified on the policy or certificate form and policy or certificate schedule;
- Our presumption of reasonableness when applying penalties for failure to utilize designated providers may not exceed a 50% benefit reduction. All covered expenses disallowed due to the failure to utilize designated providers need not be used to satisfy policy out-of-pocket expense limits.

- The department remains concerned about treatment provided by network providers when benefits have been retroactively denied due to failure to meet pre-admission review or medically necessary requirements. Verify that PPO treatment will meet the standard described in this section. Additional clarification of this issue is described below.

- If prior-authorization review or approval is required, we will not approve policy forms that require the insured to obtain prior approval for PPO provided (or referred) treatment. If the insured received treatment from the network provider, but the provider fails to comply with the pre-authorization, continued stay review and/or discharge planning, no penalty may be imposed against benefit amounts. We consider such penalties unfair and misleading. This also applies to out of network referrals. It must be the designated provider's responsibility to see that the treatment provided is medically necessary. Further, treatment provided by a network provider may not be denied due to the failure to meet "pre-admission review" or "medically necessary" requirements. In accordance with Minn. Stat. §62A.02, Subd. 3(2) the department considers it unfair to reduce coverage, when the insured is referred to a non-network provider by a preferred provider.

For example, if the individual insured went to a network provider for surgery and was referred to a network hospital, surgeon or laboratory, but was referred to a non-network anesthesiologist, no penalty may be imposed. It must be the responsibility of the network provider to establish appropriate referrals.

Standards for Prior Authorizations Minn. Stat. §72A.201, Subd. 4a.

If a policy of accident and sickness insurance or a subscriber contract requires pre-authorization approval for any non-emergency services or benefits, the decision to approve or disapprove the requested services or benefits must be processed in accordance with Minn. Stat. §62M.07. An insured must be able to rely on an authorization for coverage subject to the following:

An authorization may be subject to conditions such as:

1) The premiums have been paid,

2) The insured has not exceeded the lifetime or benefit maximum,

3) The condition is not subject to a pre-existing condition limitation period,

4) The procedure that is authorized is the service that is billed by the provider,

5) Policy deductibles, coinsurance and co-pay provisions will continue to apply,

6) Requests for prior authorization must be submitted in writing; telephone requests for prior authorization are not acceptable.

Treatment by Preferred (Participating) Providers and Referrals to Non-Participating Providers.

Contracts must specify that the responsibility to pre-certify various conditions lies with the network provider that is providing the treatment. Requirements that the insured must obtain prior approval must be deleted.